



REFILL TOO SOON PRIOR APPROVAL WORKSHEET

TIME
____ / ____ / ____
DATE OF REQUEST

Provider Name: _____
Pharmacist Name: _____
Provider Phone Number: _____
Provider Identification Number (12 digits): _____
Recipient Name: _____
Recipient Identification Number (9 digits): _____
Date of Service: _____

Drug #1: _____
NDC #: _____
Directions: _____
Quantity: _____
Reason for Request: _____

Drug #3: _____
NDC #: _____
Directions: _____
Quantity: _____
Reason for Request: _____

Last Rx Date: _____
Last Days Supply: _____
Last Quantity: _____
Last Pharmacy: _____

Last Rx Date: _____
Last Days Supply: _____
Last Quantity: _____
Last Pharmacy: _____

Drug #2: _____
NDC #: _____
Directions: _____
Quantity: _____
Reason for Request: _____

Drug #4: _____
NDC #: _____
Directions: _____
Quantity: _____
Reason for Request: _____

Last Rx Date: _____
Last Days Supply: _____
Last Quantity: _____
Last Pharmacy: _____

Last Rx Date: _____
Last Days Supply: _____
Last Quantity: _____
Last Pharmacy: _____

Decision: "P" - No Action: _____ "R" - Approved: _____ Date / By: _____

RPh Called Back / Date / By: _____